TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Sentrix Pharmacy and Discount, L.L.C.

Respondent Name
Fort Bend County

MFDR Tracking Number
M4-16-2905-01

Carrier's Austin Representative
Box Number 29

MFDR Date Received
May 23, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On 5/16/16, after the 45-day statutory time frame, the carrier submitted the attached EOB, however this was an untimely denial."

Amount in Dispute: $2,394.24

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Submitted documentation does not include a position statement from the respondent. Accordingly, this decision is based on the information available at the time of review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 18, 2016	Pharmacy Services - Compound	$2,394.24	$2,394.24

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.502 sets out the procedures for pharmaceutical benefits.
3. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
4. 28 Texas Administrative Code §134.530 sets out the closed formulary requirements for claims not subject to certified networks.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - W3W – No reimbursement recommended on reconsideration. Previous recommendation was in accordance with the Workers' Compensation State Fee Schedule.

- 197D – Precertification/authorization/notification absent. *Health care treatments/services that are not recommended, not listed, or under study by the ODG, or exceeded the ODG in frequency or duration require pre-authorization.*

Issues

1. Did the workers' compensation carrier respond to the medical fee dispute?
2. What are the services in dispute?
3. Is Fort Bend County's reason for denial of payment supported?
4. What is the total reimbursement for the services in question?

Findings

1. The Austin carrier representative for Fort Bend County is Pappas and Suchma, P.C. Pappas and Suchma, P.C. acknowledged receipt of the copy of this medical fee dispute on June 2, 2016.

   28 Texas Administrative Code §133.307 states, in relevant part:

   (d) Responses. Responses to a request for MFDR shall be legible and submitted to the division and to the requestor in the form and manner prescribed by the division.
   (1) Timeliness. The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile **within 14 calendar days after the date the respondent received the copy of the requestor's dispute** [emphasis added]. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information.

   Review of the documentation finds that no response has been received from Pappas and Suchma, P.C. to date. The division concludes that the carrier failed to respond within the timeframe required by §133.307(d)(1). For that reason the division will base its decision on the information available.

2. Sentrix Pharmacy and Discount, L.L.C. (Sentrix) is seeking reimbursement of $2,394.24 for a pharmaceutical compound dispensed on February 18, 2016 consisting of the following ingredients:

   - Salt stable LS Base AWP Cream, NDC 00395602157, 192.0 grams
   - Flurbiprofen 10%, NDC 38779036205, 24.0 grams
   - Tramadol 10%, NDC 38779237409, 24.0 grams

   This is the service considered for the dispute in question.

3. Fort Bend County denied disputed services with claim adjustment reason code 197D – "Precertification/ authorization/notification absent," adding an additional note stating, "Health care treatments/services that are not recommended, not listed, or under study by the ODG, or exceeded the ODG in frequency or duration require pre-authorization."

   28 Texas Administrative Code §134.500(3) defines the closed formulary as "all Food and Drug Administration (FDA) approved prescription and nonprescription drugs prescribed and dispensed for outpatient use" except those requiring preauthorization. 28 Texas Administrative Code §134.530(b)(1) states:

   Preauthorization is **only** [emphasis added] required for:
   (A) drugs identified with a status of "N" in the current edition of the *ODG Treatment in Workers' Comp* (ODG) / Appendix A, *ODG Workers' Compensation Drug Formulary,* and any updates;
   (B) any compound that contains a drug identified with a status of "N" in the current edition of the *ODG Treatment in Workers' Comp* (ODG) / Appendix A, *ODG Workers' Compensation Drug Formulary,* and any updates; and
   (C) any investigational or experimental drug for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, but which is not yet broadly accepted as the prevailing standard of care as defined in Labor Code §413.014(a).

   Further, 28 Texas Administrative Code §134.530(d) states:

Treatment guidelines. Except as provided by this subsection, the prescribing of drugs shall be in accordance with §137.100 of this title (relating to Treatment Guidelines), the division's adopted treatment guidelines.

(1) Prescription and nonprescription drugs included in the division's closed formulary and recommended by the division's adopted treatment guidelines may be prescribed and dispensed without preauthorization.

(2) **Prescription and nonprescription drugs included in the division's closed formulary that exceed or are not addressed by the division's adopted treatment guidelines may be prescribed and dispensed without preauthorization** [emphasis added].

(3) Drugs included in the closed formulary that are prescribed and dispensed without preauthorization are subject to retrospective review of medical necessity and reasonableness of health care by the insurance carrier in accordance with subsection (g) of this section.

The division finds that the ingredients noted in the compound in question are included in the division's closed formulary as the ingredients consist of FDA approved drugs and inactive ingredients and do not include a drug identified with a status of "N" in the current edition of the ODG, *Appendix A*. Fort Bend County failed to raise any other defenses for denial of the disputed compound. Therefore, the division concludes that preauthorization for the services in question did not require preauthorization and Fort Bend County's denial for this reason is not supported.

4. 28 Texas Administrative Code §134.503 applies to the compound in dispute and states, in pertinent part:

(c) The insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of:

(1) the fee established by the following formulas based on the average wholesale price (AWP) as reported by a nationally recognized pharmaceutical price guide or other publication of pharmaceutical pricing data in effect on the day the prescription drug is dispensed:

(A) Generic drugs: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount;

(B) Brand name drugs: ((AWP per unit) x (number of units) x 1.09) + $4.00 dispensing fee per prescription = reimbursement amount;

(C) When compounding, a single compounding fee of $15 per prescription shall be added to the calculated total for either paragraph (1)(A) or (B) of this subsection; or

(2) notwithstanding §133.20(e)(1) of this title (relating to Medical Bill Submission by Health Care Provider), the amount billed to the insurance carrier by the:

(A) health care provider; or

(B) pharmacy processing agent only if the health care provider has not previously billed the insurance carrier for the prescription drug and the pharmacy processing agent is billing on behalf of the health care provider.

The compound in dispute was billed by listing each drug included in the compound and calculating the charge for each drug separately as required by 28 Texas Administrative Code §134.502(d)(2).

Each ingredient is listed below with its corresponding reimbursement amount as applicable.

Ingredient	NDC & Type	Price/ Unit	Total Units	AWP Formula §134.503(c)(1)	Billed Amt §134.503 (c)(2)	Lesser of (c)(1) and (c)(2)
Salt Stable Cream Base	00395602157 Brand Name	$3.36	192.0 gm	$3.36 x 192 x 1.09 = $703.18	$645.12	$645.12
Flurbiprofen 10%	38779036205 Generic	$36.58	24.0 gm	$36.58 x 24 x 1.25 = $1,097.40	$877.92	$877.92
Tramadol 10%	38779237409 Generic	$36.30	24.0 gm	$36.30 x 24 x 1.25 = $1,089.00	$871.20	$871.20
					Total	$2,394.24

The total reimbursement is therefore $2,394.24. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $2,394.24.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $2,394.24, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	January 13, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.